

PRINTED: 09/07/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5801	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2012
NAME OF PROVIDER OR SUPPLIER BRIDGE AT SOUTH PITTSBURG, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies Based on observation, testing, and document review, it was determined the facility had no life safety deficiencies.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
*Dennis Adams*TITLE
Debra Horta

(X6) DATE

9-19-2012

STATE FORM

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If continuation sheet 1 of 1